NOTICE OF AGREEMENT
TO USE A NAMED INDEPENDENT MEDICAL EXAMINER

NWCC Form 67-2 (4/08)

Initiator: Name, Address, and Telephone

Representing:

Employer: Name, Address, Telephone, and Attorney's Name (if represented in this case)

Insurer: Name, Address, Telephone, and Attorney's Name (if represented in this case)

Nebraska Workers' Compensation Court
State Capitol Building
P.O. Box 98908 800-599-5155
Lincoln, NE 68509-8908 402-471-6468

Attach a separate sheet of paper to add additional information.

The parties have agreed to use the physician named below to perform an independent medical examination.

_____
Employer/Insurer/Representative Signature

_____
Employee/Representative Signature

Employee: Name, Social Security #, Address, Telephone, and Attorney's Name (if represented in this case)

Date of Injury:

Description of Injury:

Name, Address, and ***Specialty*** of all physicians who have treated or examined the employee for this injury:

Name of Agreed Upon Independent Medical Examiner: _____

Signature required if the physician is not on the list of court-appointed independent medical examiners

I acknowledge that I am not on the list of court-appointed independent medical examiners. However, I agree to perform an independent medical examination for the above employee in accordance with the Nebraska Workers' Compensation Act and the Court's Rules of Procedure (63–65).

Physician Signature: _____ Date: _____

Questions submitted to the independent medical examiner:

Submit with certificate of service as proof that all other parties have been served a copy of the request.